

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15002**

No. 300  
10. 48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1002  
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FILED MAY 3- 1952  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 1127

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. LENGTH OF STAY (in this place) <u>45 DAYS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7756 Bonhomme Ave.</u>		d. STREET ADDRESS (If rural, give location) <u>7756 Bonhomme Ave.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANCIS</u>		b. (Middle) <u>NEAL</u>	
		c. (Last) <u>McGRATH</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>April 26 1952</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7, 1877</u>
9. AGE (In years last birthday) <u>75</u>		10. MONTHS <u>0</u>	11. DAYS <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rollins-McGrath</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>De Soto, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Michael McGrath</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Day</u>	
14. NAME OF HUSBAND OR WIFE <u>Mathilda McGrath</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mathilda McGrath, Clayton, Mo.</u>		ADDRESS <u>Clayton, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of sigmoid</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>153X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/25 1952</u> , to <u>4/26 1952</u> , that I last saw the deceased alive on <u>7/26 1952</u> , and that death occurred at <u>7:00 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>J. D. Staehle</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>102 W. Adams, Keokuk</u>	
23c. DATE SIGNED <u>4/29/52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/30/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
DATE REC'D BY LOCAL REG. <u>4-29-52</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis H. Papp Inc. Keokuk</u> ADDRESS _____	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Francis Williamson

Licensed Embalmer No. 3865

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.